Public Operating Engineers Fund: Plan D PPO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-800-844-8392**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500**/person; **$1,000**/family. Deductible does not apply to Contract Provider office visits, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, the adult physical exam benefit for Non-Contract Providers. Copays do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50/visit** for emergency room charges for an Emergency Medical Condition. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes, The **Out-of-Pocket Limit** for Contract Providers is **$5,000**/person, **$10,000**/family. As part of this limit, the coinsurance maximum for Contract Providers is **$3,000**/person, **$6,000**/family. The **Out-of-Pocket Limit** for outpatient prescription drugs at a Network Pharmacy is **$1,600**/person and **$3,200**/family.	The **Out-of-Pocket Limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	The **Out-of-Pocket Limit** for Contract Providers does not include premiums, balance-billed charges, healthcare this plan does not cover, charges in excess of benefit maximums and allowed charges, dental and vision plan expenses, outpatient prescription drug expenses, and Non-Contract Provider copays and coinsurance (except an Emergency room visit in cases of an emergency). The **Out-of-Pocket Limit** for in-network prescription drugs does not include premiums, healthcare this plan does not cover, amounts over the generic equivalent if you choose a brand drug when a generic equivalent is available, dental and vision plan expenses, and out-of-network copays and coinsurance	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of **Anthem Blue Cross Contract providers, see www.bluecrossca.com or call 1-800-844-8392.** For a list of **Blue Card Contract providers outside the state of California, see www.bluecares.com or call 1-800-844-8392.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-844-8392**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call **1-800-844-8392** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Contract **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use A Contract Provider	Your Cost If You Use Non-Contract Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	**40% coinsurance	In this chart, where you see "**" it means that for Non-Contract providers, you pay amounts above the Plan's allowed charge. LiveHealth online $15 per visit (deductible waived).
	Specialist visit	$20 copay/visit	**40% coinsurance	
	Other practitioner office visit	Chiropractor: 20% co-insurance Acupuncture: 20% coinsurance	Chiropractor: **40% co-insurance Acupuncture: 40% coinsurance	Chiropractor: maximum 40 visits/year (combined with Physical Therapy). Acupuncture: maximum 1 visit/week, 12 weeks/diagnosis
	Preventive care/screening/ immunization	No charge	100% for routine exam (up to $250/exam). Other covered services *40% coinsurance	Plan covers preventive services/supplies required by the Health Reform law. Age and frequency guidelines apply
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	**40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	**40% coinsurance	Imaging tests require pre-authorization by American Imaging Management.

Common Medical Event	Services You May Need	Your Cost If You Use A Contract Provider	Your Cost If You Use Non-Contract Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available from OptumRx at www.optumrx.com or call (855) 672-3644	Generic drugs	Retail Pharmacy (34-day supply): $5 copay/script; Mail Order (90-day supply): $10 copay/script.	You pay 100%. Then the Plan reimburses no more than it would have paid had you used a Contracted retail pharmacy. If cost of the drug is less than the copay, you pay just the drug cost.	• Contact OptumRx for information on prescriptions subject to preauthorization and step therapy. • If you choose a brand name drug when a generic equivalent is available and medically appropriate, the Fund will only pay up to the reasonable cost of the generic equivalent. Any excluded amounts will not count to the out of pocket maximum. • You may obtain a 90-day supply of maintenance drugs at a network retail pharmacy (will pay (3) retail copays for each 90-day supply). • No charge for FDA approved generic contraceptives (or brand drug if generic is medically inappropriate.
	Brand Formulary Drugs	Retail Pharmacy (34-day supply): 10% coinsurance (max copay $100). Mail Order (90-day supply): 5% coinsurance (max copay $100).		
	Brand Non-Formulary Drugs	Retail Pharmacy (34-day supply): 25% coinsurance (max copay $200). Mail Order (90-day supply): 15% coinsurance (max copay $200).		
	Specialty Drugs	20% coinsurance up to following maximum copay/script: • Generic: $50 • Preferred Brand: $100 • Non-Preferred Brand: $200	Not covered (except for chemotherapy drugs)	Specialty Drugs must be obtained through OptumRx or there are no benefits available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	**40% coinsurance	$1,000 maximum/visit for Non-Contract providers
	Physician/surgeon fees	20% coinsurance	**40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	20% co-insurance after $50 emergency room deductible	**20% coinsurance after $50 emergency room deductible	---none---
	Emergency medical transportation	20% co-insurance	**20% coinsurance	
	Urgent care	20% co-insurance	**20% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use A Contract Provider	Your Cost If You Use Non-Contract Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	**40% coinsurance	Elective hospital admission requires pre-authorization
	Physician/surgeon fee	20% coinsurance	**40% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: $20 copay/visit, other outpatient services 20% coinsurance	**40% coinsurance	LiveHealth online $15 per visit (deductible waived).
	Mental/Behavioral health inpatient services	20% coinsurance	**40% coinsurance	Elective hospital admission requires preauthorization
	Substance use disorder outpatient services	Office visit: $20 copay/visit, other outpatient services: 20% coinsurance	**40% coinsurance	LiveHealth online $15 per visit (deductible waived).
	Substance use disorder inpatient services	20% coinsurance	**40% coinsurance	Elective hospital admission requires preauthorization with ARP (Assistance Recovery Program)
If you are pregnant	Prenatal and postnatal care	No charge	**40% coinsurance	Ultrasound payable as a diagnostic test
	Delivery and all inpatient services	20% coinsurance	**40% coinsurance	Pre-authorization required for extended hospital stays. You pay 100% of delivery charges for dependent children.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	**40% coinsurance	Daily max 1 visit. 60 visits/calendar year.
	Rehabilitation services	20% coinsurance	**40% coinsurance	Outpatient physical therapy max benefit is 40 visits/year (combined with Chiropractic). Speech therapy when medically necessary.
	Habilitation services	20% coinsurance	**40% coinsurance	Benefits available **ONLY** for delays in childhood speech, limited to 20 visits/calendar year; 40 visits/lifetime.
	Skilled nursing care	20% coinsurance	**40% coinsurance	Maximum benefit is 100 days per year. Preauthorization required
	Durable medical equipment	20% coinsurance	**40% coinsurance	---none---
	Hospice service	20% coinsurance	**40% coinsurance	Daily max 1 visit. 60 visits/calendar year.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Vision benefits are administered separately by VSP.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	Dental services are administered separately by Delta Dental

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (available only through a separate Delta Dental Plan up to $2,500/person)
- Infertility treatment
- Long-term care
- Routine eye care (available only through a separate vision plan with VSP)
- Weight loss programs (except as required by Health Reform)

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (1 visit/week, 12 visits/diagnosis)
- Bariatric Surgery (must be medically necessary)
- Chiropractic care (up to 40 visits/year combined with physical therapy)
- Hearing aids (up to $450/ear, every 3 years)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care (foot orthotics not covered)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 844-8392. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at (800) 844-8392. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 844-8392.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 844-8392.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 844-8392.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 844-8392.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,840
- **Patient pays** $1,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$1,160
Limits or exclusions	$30
Total	**$1,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,250
- **Patient pays** $1,150

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$440
Coinsurance	$170
Limits or exclusions	$40
Total	**$1,150**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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